GER

A plan to address substance use and misuse in Louisville





ACKNOWLEDGEMENTS

Special thanks to each organization and community member who provided insight and expertise to make this action plan a reality. Our community thanks those who are directly impacted by substance use disorder, their families, friends, and neighbors who contributed their experiences to this plan.

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Kentucky Injury Prevention and Research Center

Kentucky Recovery Resource Center

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Data Note: We use Vital Statistics data throughout this report. This data indicates deaths of Louisville residents no matter where their death occured.



GREG FISCHER Mayor



DEAR COMMUNITY MEMBERS,

Our vision is a healthy Louisville where everyone and every community thrives.

Our community, like so many across the country, is facing an opioid epidemic that has resulted in thousands of overdoses and hundreds of deaths. Addressing this crisis is a top priority for our city as we work to prevent substance use disorder, overdoses, and death. As many in our community know, the issue of substance use disorder does not begin and end with opioids; there are many substances like alcohol, tobacco, and other drugs impacting many people across our community.

Substance use disorder is a complex, but not insurmountable problem, especially when we come together as a community to align our resources and expertise. Louisville is taking a collaborative approach—and using best practices from other communities—to bring the epidemic under control. As with all emergencies, we needed an updated plan to help us accelerate our efforts to combat the crisis.

We began the work of creating a city-wide plan by convening community members who are passionate about changing the course of substance use disorder in Louisville, including: people in recovery, leaders of nonprofits, law enforcement, health care providers, social workers, school officials, concerned parents, scholars, and many more. These community members spent last fall working in four groups focused on distinct issues: Primary Prevention and Education, Opioid Overdose Prevention, Recovery Support, and Expanding Access to Treatment. They reviewed data, explored best practices and examples from our own city and other communities and discussed potential solutions.

From their insights, expertise, and recommendations come this comprehensive report and two-year action plan. This plan is designed to better coordinate ongoing efforts, add new efforts to fill in the gaps, and engage new partners and resources to tackle the issue of substance use disorder.

Finding solutions and creating a more resilient community is a task that requires the involvement of all of us. We look forward to working with you to continue to make Louisville a place where everyone and every community can thrive.

In community,

Greg Fischer Mayor

Dr. Sarah Moyer Director, Chief Health Strategist

EXECUTIVE SUMMARY

We want a Louisville where everyone and every community thrives. Together we are creating a Louisville where every person can have a healthy and fulfilling life, and reach their full potential. We are using our resources to meet the challenges brought on by substance use disorder; we can meet these challenges at every level of our community, including in our homes, with family and friends, at work, in our largest institutions, and within government. When we come together we can foster hope, healing, and recovery in Louisville.

While the challenges of substance use disorder may seem daunting, they can be met and overcome with a public health approach. It is an approach that has worked for other issues, including childhood infectious diseases, lead poisoning, and motor vehicle accidents, leading to a significant increase in life expectancy in the United States over the past 120 years.

A public health approach involves studying root causes, identifying risk factors, designing interventions to address these factors, and evaluating the effectiveness of those interventions. Many stakeholders working together across many sectors can improve the health of our community.

This report/action plan was designed with the input of many partners from across Louisville committed to addressing substance use disorder in our community.

In the next two years, Louisville will provide:



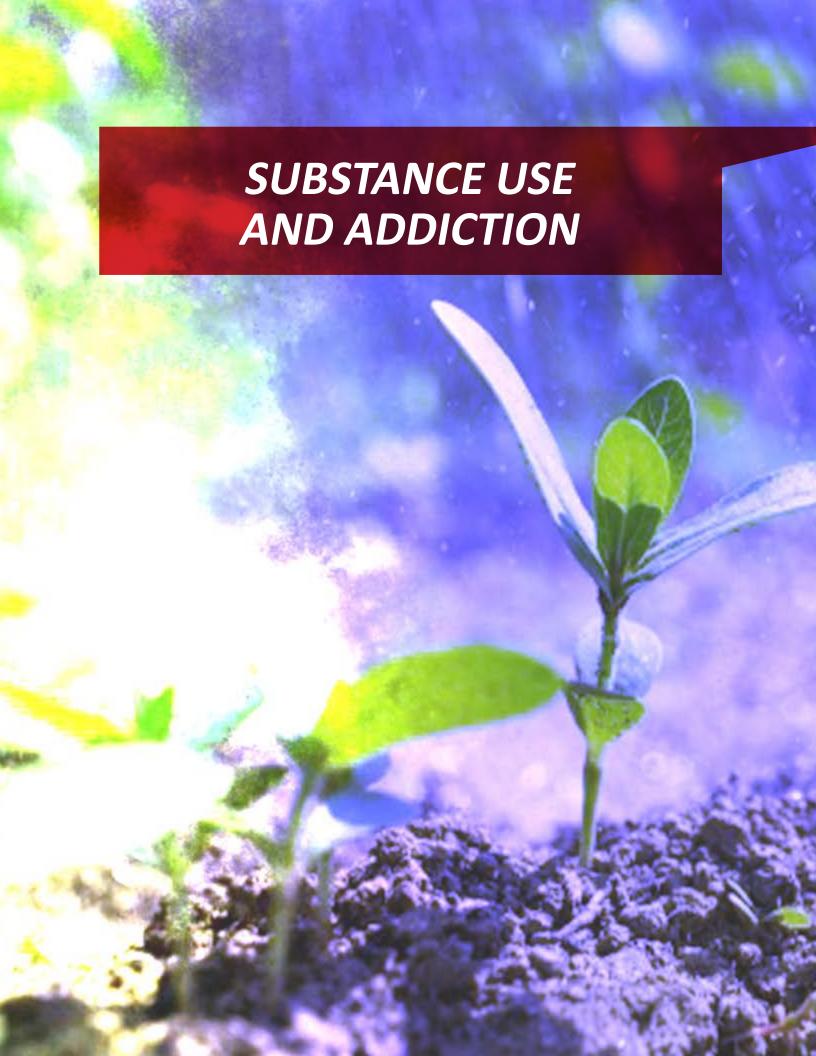
- 1. Prevent and reduce youth substance use
- 2. Increase trauma informed care
- 3. Reduce stigma



- 4. Increase harm reduction
- 5. Expand diversion from emergency rooms and jail
- 6. Improve connection to treatment
- 7. Measure the quality of treatment programs



- 8. Establish guidelines for sober living houses
- 9. Make expungement affordable
- 10. Improve job placement



"Alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on individuals, families, and society. Neighborhoods and communities as a whole are also suffering as a result of alcohol- and drug-related crime and violence, abuse and neglect of children, and the increased costs of health care associated with substance misuse. It is estimated that the yearly economic impact of substance misuse is \$249 billion for alcohol misuse and \$193 billion for illicit drug use."

Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health



Most people who live in Louisville know someone who has a substance use disorder and the consequences that come with it. Substance use disorder is a clinical diagnosis that describes the brain disease caused by the recurrent use of substances such as alcohol, illicit drugs and tobacco. Substance use disorder is a significant public health issue in our city.² It is a community problem that requires community solutions.

The current national opioid epidemic has been called the worst drug crisis in American history.³ According to the U.S. Centers for Disease Control and Prevention, during 2015 there were 52,404 overdose deaths in the United States, including 33,091 that involved an opioid. In 2016, an average of 115 people in the United States died every day from an opioid overdose.⁴



Like much of the country and the region, opioid and other drug use in Louisville has increased over the past five years with devastating results. Hospitalizations and emergency room visits due to severe acute drug poisoning rose dramatically from 2830 visits in 2012 to 4437 visits in 2016; drug overdose deaths have also soared.⁵

In 2016, the age-adjusted drug overdose death rate in

Louisville was more than double what it was in 2011. Substance use disorder and overdose impacts every neighborhood. In 2016, Metro Emergency Medical Services (EMS) performed overdose runs in every single Louisville Metro ZIP Code, without exception.

While the use of illicit drugs garners significant media attention and community concern, tobacco and alcohol use remain far more pervasive throughout Louisville and affect many more people.

While smoking rates have been gradually coming down in recent years, the adult smoking rate of 25.5% in Louisville remains well above the national rate of 15.1%.⁸ According to the CDC National Youth Tobacco Survey, the use of e-cigarettes among young people has surpassed the use of conventional cigarettes since 2011.⁹ Electronic cigarette use, particularly among young people, threatens to reverse the trend of making nicotine addiction less socially acceptable and of falling smoking rates.

Alcohol use disorder remains a serious problem across the United States. Government organizations like the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) continue to track the effects of alcohol on public health. The age-adjusted alcohol-induced death rates in Louisville Metro continue to be higher than both the state and national rates.¹⁰

While the challenges of drug, tobacco, and alcohol use across Louisville may seem daunting, they can be met and overcome. A public health approach to this issue can meet the challenges our community faces; it is an approach that has worked well in many other arenas, including safe water and air, childhood immunizations, and prenatal care. This progress has led to a significant increase in life expectancy in the United States over the past 120 years. The process involves studying root causes, identifying risk factors, designing interventions to address these factors, and evaluating the effectiveness of programmatic efforts. Many stakeholders working together across many sectors can improve the health of our community.

This report examines the root causes of substance use disorder specifically caused by recurrent use of illicit drugs, tobacco, and alcohol in Louisville. It takes a science-based look at the problem as it presently exists. It identifies a way our community can collaborate on solutions and identifies resources already in place. The report makes best practice recommendations to bring about the day when substance use disorder in Louisville is prevented, controlled, and treatment is widely and readily available.

This plan was developed with the contributions of many community organizations and individuals working together in workgroups to identify strategies that can be undertaken to address substance use disorder in Louisville. Ten major strategies have been identified for our community to take on over the next 2 years. Our community will take on these strategies at this time because research and evidence indicate that they can have the greatest impact drawing on our current community assets. We know much more can and must be done, and so this document includes the full list of recommendations identified by the workgroups and community feedback through the planning process.

NEVER BEFORE HAVE WE NEEDED TO WORK SO CLOSELY WITH PARTNERS THROUGHOUT OUR COMMUNITY TO ENSURE OUR SYSTEMS OF CARE ARE STRONG, PREVENTION EFFORTS ARE ENHANCED, AND TREATMENT IS ACCESSIBLE.

- Jennifer Hancock, LCSW

TIMELINE OF SUBSTANCE USE IN AMERICA

This timeline demonstrates how policies and practices have shaped today's landscape.

1875

The First American Anti-Drug Law: San Francisco ordinance that outlawed the smoking of opium in opium dens. The Harrison Narcotics Act: U.S. federal law that regulated and taxed the production, importation, and distribution of opiates and coca products.

1789 Temperance Movement: A public push for temperance — a limitation of alcohol consumption or a total abstinence from alcohol, with the founding of the first American temperance society in Connecticut.

1890

The First
Congressional
Act: The First
Congressional
Act levied taxes
on morphine
and opium.

1920

1914

Prohibition: The U.S. government mandated the ban of alcohol manufacturing, sales and consumption with the 18th Amendment to the Constitution.

1937

The Marihuana Tax Act: A U.S. federal law that imposed tax on the sale of cannabis, hemp, or marijuana.

1804

Morphine: Morphine is distilled from opium for the first time.

1910

Driving Under the Influence (DUI): New York City passed the first law against driving while intoxicated.

1909

Opium Exclusion Act: Congress passed an act that barred the importation of opium for smoking as of April 1, 1909.

1933

End of
Prohibition:
The 18th
Amendment
was replaced
by the 21st
Amendment to
the Constitution,
and Prohibition
came to an end.

1947

Methadone: Eli Lilly Company introduced methadone to the U.S. as a potential aid those with an addiction to heroin.

1924

Heroin Act: Prohibited the manufacture, importation and possession of heroin — even for medicinal use.

1898

Heroin Produced: Heroin is first produced commercially by the Bayer Company. It is dispensed to individuals who are addicted to morphine.

1965

Federal Cigarette Labeling and Advertising Act: Requires a health warning on cigarette packages.

1965

Drug Abuse Control Amendment: Restricted research into psychoactive drugs, such as LSD, by requiring FDA approval.

1970

Public Health Cigarette Smoking: Prohibits cigarette advertising on television and radio.

1970

First Methadone Clinic Opens in NYC.

1973

Drug Enforcement Agency (DEA): By Executive Order, the DEA was formed to take place of the Bureau of Narcotics and Dangerous Drugs.

1989

Mothers against Drunk Drivers (MADD): Formed to stop underage drinking and promote awareness of the problem of drunk driving.

1996

Pain the "Fifth Vital Sign": American Pain Society began a campaign that pain was the fifth vital sign.

1996 OxyContin: Purdue Pharma releases OxyContin, timed-release oxycodone, marketed largely for chronic-pain patients.

$\circ \infty \circ \circ \circ \circ$

1970'S

War on Drugs and the Controlled Substance Act: Classified controlled substances into five schedules and put select plants, drugs, and chemical substances under federal jurisdiction.

1964

First Report of the Surgeon General's Advisory Committee on Smoking and Health: Identifies smoking as a cause of increased mortality rates.

1960'S

The National Traffic Highway Safety Association: Confirmed the connection between alcohol intoxication and impairment while operating a motor vehicle.

EARLY 1990S

Patient Right to Pain Relief Begins: Doctors began prescribing opiates (and other medications), as patients felt they have a right to pain relief.

1988

Anti-Drug Abuse Act of 1988: Established the Office of National Drug Control Policy (ONDCP) in the Executive Office of the President.

1984

The National Minimum Drinking Age Act of 1984: The bill forced all states to raise their drinking age from 18, 19, or 20 to 21.

1986

Needle Exchange Programs: The first organized public distribution of drug injection equipment in the U.S. happened in New Haven, Connecticut, and Boston, Massachusetts.

2009

Family Smoking Prevention and Tobacco Control Act: Gives the Food and Drug Administration (FDA) the power to regulate the tobacco industry. Also bans flavored cigarettes, places limits on the advertising of tobacco products to minors and requires tobacco companies to seek FDA approval for new tobacco products.

2000

The Drug Addiction
Treatment Act: Enables
qualified physicians to
prescribe and/or dispense
narcotics for the purpose of
treating opioid dependency.

2001

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Added pain management to patient satisfaction surveys, resulting in increased opioid prescriptions.

2010

Fair Sentencing Act:
Reduced the disparity
between crack and
powder cocaine
sentencing; the disparity
had meant that people
faced longer sentences
for offenses involving
crack cocaine than for
offenses involving the
same amount of powder
cocaine.

2015

Kentucky Revised Statutes 218A.510 (Kentucky Harm Reduction and Syringe Exchange): Bill passed allowing local health departments to operate an outreach program in which individuals can exchange used needles and syringes for clean needles and syringes.

2016

Comprehensive Addiction and Recovery
Act of 2016: Section 303 amends the
Controlled Substance Act allowing
Nurse Practitioners and Physician
Assistants to become eligible to prescribe
buprenorphine for the treatment of
opioid use disorder.

2006

2006 Patient Limit 30/100: Allows physicians who have been certified to prescribe certain drugs for the treatment of opioid dependence under DATA2000 to treat up to 100 patients.

2006

Electronic cigarettes: Were first successfully introduced and marketed in the U.S.

2012

Kentucky House Bill 1:

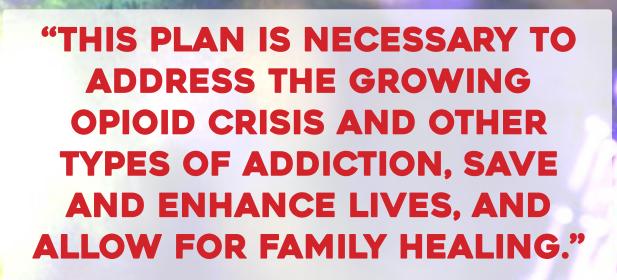
Set the mandatory prescribing and dispensing standards for controlled substances in Kentucky. This legislation led to the establishment of the Kentucky All Schedule Prescription Electronic Reporting (KASPER).

2012

Medicare Reimbursement Linked to Patient
Satisfaction: Under the Affordable Care Act, one
percent of total hospital Medicare reimbursement was
cut, unless hospitals could demonstrate a high patient
satisfaction score.

2005

Controlled Substance Act Amendment: Public law 109-56 removed the 30-patient limit on group medical practices that treat opioid dependence with buprenorphine.



- Andrew Davidson, LCSW, LCADC

"I APPRECIATE BEING TREATED RESPECTFULLY, AS A HUMAN BEING."

- Syringe Exchange Participant



DRUGS

On average, 115 people in the United States are dying each day from overdose. ¹¹ Substance use disorder is having a devastating impact on Louisville residents and their families; overdose deaths in Louisville have continued to rise since 2011 (Figure 1). A Centers for Disease Control and Prevention (CDC) study found that while opioid prescribing has fallen in some parts of the country, opioid prescribing remains considerably higher than it was prior to 1999. ¹² Many Louisvillians have turned to street opioids, such as heroin, which are readily available and are often cheaper. Beyond opioids and heroin, members of our community and their families are affected by a number of other substances including tobacco, alcohol, other prescription drugs, and illicit drugs like methamphetamines and marijuana.

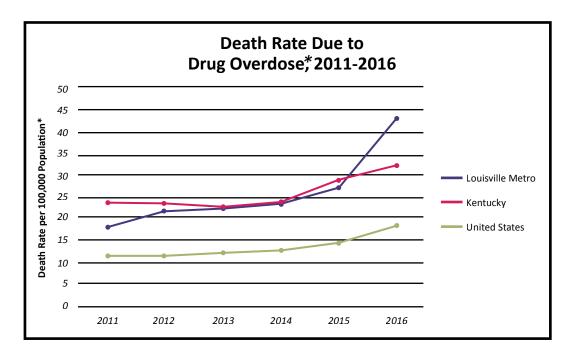


Figure 1
Death Rate Due to Drug Overdose*, 2011-2016

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

^{*}Unintentional/ Undetermined; Age-adjusted

By 2015,
according to the
CDC, enough
pills were being
prescribed for
every American
to be medicated
around the clock
for three straight
weeks.

Drug use is not a new problem in the United States. The heroin epidemic of the 1960s and 70s was spurred by soldiers returning from Vietnam who had used overseas. This epidemic, as well as the crack cocaine epidemic of the 1980s and 90s, primarily affected poor, urban areas, and people of color.¹³ The federal approach to the issue at that time was to be "tough on crime," rather than to enact a public health response strategy.

Beginning in the late 1990s and early 2000s, the rate of opioid prescriptions began to snowball. By 2015, according to the CDC, enough pills were being prescribed for every American to be medicated around the clock for three straight weeks. ¹⁴ Opioid medications can lead to dependency within just a matter of days; this flood of prescriptions led to a surge of substance use disorder. ¹⁵ There has also been a steady rise in overdose fatalities.

The most obvious health impacts of substance use are dependency, overdose, and premature death. According to the National Institute on Drug Abuse (NIDA), depending on the particular drug, health outcomes can also include heart disease, stroke, and cancer or lung disease. Substance use can worsen a person's mental health, isolate them from their support system, or impact their ability to maintain housing or employment.

Prescribed drugs, when used improperly or in excess—and the use of illicit drugs—can lead to poisoning or overdose. When this happens in great numbers, it places a significant stress on our health and human services. In Louisville, hospitalizations and ER visits due to severe acute drug poisoning, especially due to heroin, have skyrocketed over the past five years. From 2015 to 2016, Louisville Metro saw a steep increase in the number of inpatient hospitalizations and emergency department visits (Figure 2).

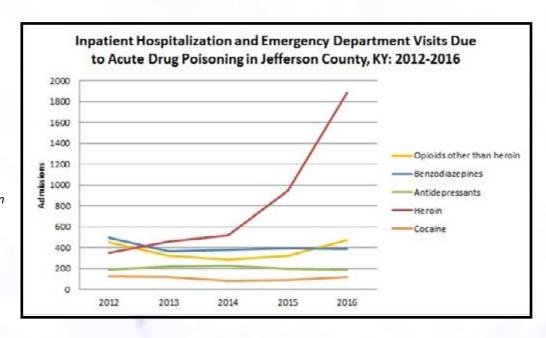


Figure 2
Inpatient Hospitalization and
Emergency Department Visits Due
to Acute Drug Poisoning in Jefferson
County, KY, 2012-2016

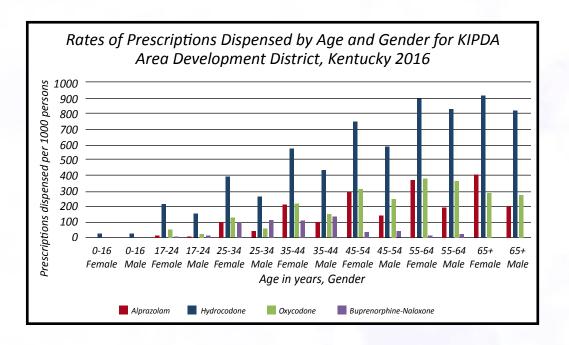
Drug-related inpatient hospitalizations and emergency department visits by County: 2012-2016. Kentucky Injury Prevention and Research Center. May 2017. Retrieved from http://www.mc.uky.edu/kiprc/pubs/overdose/county-profiles.html. January 2018

Hospitalizations for acute heroin poisoning in Louisville Metro in 2016 were 5 times higher than in 2012 (Figure 2). This trend contrasts to that of other drugs, such as benzodiazepines and cocaine, which remained relatively stable over this time frame. Opioid related hospitalizations were also 2.5 times higher in 2016 than in 2012 (Figure 2). 20

A closer examination shows the availability of different kinds of prescribed opioids in our community. In the Kentuckiana Regional Planning & Development Area (KIPDA), which includes Jefferson County and surrounding counties, hydrocodone prescriptions were dispensed to females of all ages at higher rates than males—with the highest dispensing rate among females ages 65 and older (Figure 3).²¹

Figure 3
Rates of Prescriptions
Dispensed by Age and
Gender for KIPDA Area
Development District,
Kentucky 2016

2016 Annual KASPER Threshold Analysis Report. Kentucky Injury Prevention and Research Center. 2017. Retrieved from http://www.mc.uky.edu/kiprc/ files/drug/2017/2016-KASPER-Annual-Threshold-Report.pdf. January 2018.²²



Substance use in Louisville is a community-wide issue, affecting every neighborhood. In 2016, Metro Emergency Medical Services (EMS) performed overdose runs in every single Louisville Metro ZIP Code, without exception (Figure 4).²³

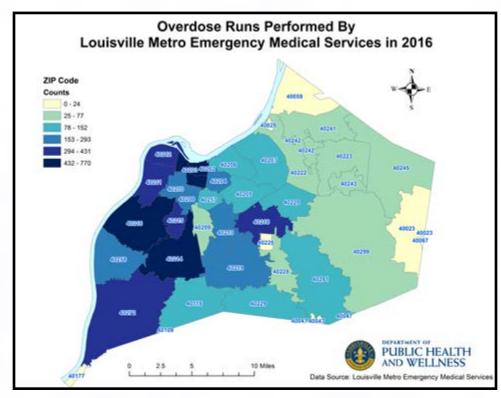


Figure 4Overdose Runs Performed by Louisville Metro Emergency Medical Services in 2016

Louisville Metro Emergency Medical Services, 2016

Overdoses tax our emergency services and health care providers. Unfortunately, not everyone who overdoses is able to survive. Substance use disorder is proving fatal for many Louisville residents; overdose deaths in Louisville have risen every year since 2011 (Figure 5).²⁴

Drug Related Death Rate and Counts*			
YEAR	TOTAL # OF DEATHS	DEATH RATE PER 100,00*	
2011	134	18.2	
2012	161	21.9	
2013	170	22.9	
2014	176	27.2	
2015	205	27.2	
2016	312	43.0	

Figure 5
Drug Related Death Rates and Counts

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Regardless of drug, Louisville's overdose death rate is more than double the national rate. In 2015, Louisville's overdose death rate for all drugs exceeded that of Kentucky and continues to climb²⁵ (Figure 1). In 2016, the rate was 43 per 100,000 residents (Figure 1). As with overdoses, every part of the Louisville community is experiencing the effects of drug overdose deaths. From 2011 - 2016, there were overdose deaths in nearly every Louisville ZIP Code (Figure 6).²⁶

"This program saved my life."

- MORE Center Participant

^{*} Age-adjusted

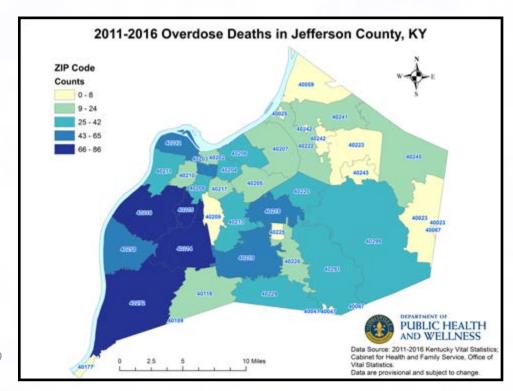


Figure 62011-2016 Overdose Deaths in Jefferson County, KY

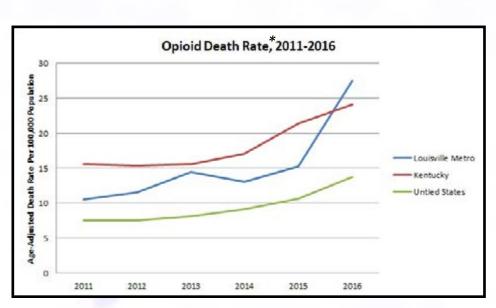
2011-2015 Kentucky Vital Statistics. Age-adjusted to 2000 U.S. Standard Population.

Opioids are in large part driving the increase in overdose deaths. The age-adjusted opioid death rates climbed from 2011 to 2016 in Louisville Metro, Kentucky as well as nationwide. In 2016, Louisville Metro's opioid death rate surpassed the rate for Kentucky (Figure 7).²⁷

Figure 7 Opioid Death Rate*, 2011-2016

*Unintentional/undetermined; Age-adjusted

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.



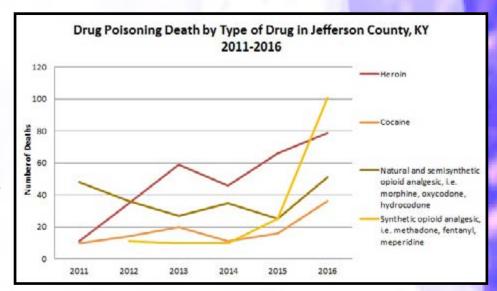
The cause of overdose deaths has changed over time with the change of drug supply. In 2016, overdose deaths caused by synthetic opioid analgesics, such as fentanyl, were 10 times higher than in 2012. Additionally, heroin-related overdose deaths were 7 times higher than in 2011 (Figure 8).²⁸

Figure 8

Drug Poisoning Death by Type of Drug in Jefferson County, KY, 2011-2016

*Unintentional/undetermined drug poisoning death

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.



From 2011 to 2016, the non-Hispanic White population had a higher age-adjusted death rate compared to the non-Hispanic Black population (non-Hispanic White: 18.6 deaths per 100,000 population; non-Hispanic Black 9.5 deaths per 100,000 population), and males had a higher death rate than females (male: 21.3 death per 100,000 population; female: 9.6 deaths per 100,000 population) in Louisville Metro (Figure 9).²⁹

Figure 9

Average Opioid Related

Overdose Death Rates by
Race and Sex, 2011-2016

* Age-adjusted

Centers for Disease
Control and Prevention,
National Center for Health
Statistics. Underlying
Cause of Death 19992016 on CDC WONDER
Online Database, released
December, 2017. Data are
from the Multiple Cause
of Death Files, 1999-2016,
as compiled from data
provided by the 57 vital
statistics jurisdictions
through the Vital Statistics
Cooperative Program.

Average Opioid Related Overdose Death Rates by Race and Sex, 2011-2016*						
	Louisville Metro		Kentucky		United States	
	COUNTS	RATES	COUNTS	RATES	COUNTS	RATES
TOTAL	682	15.3	4629	18.1	178131	9.4
White	576	18.6	4388	19.9	139590	12.0
Black	90	9.5	184	8.5	19880	8.0
Hispanic	11	**	37	4.4	14398	4.6
Other	**	**	14	**	3064	2.3
Male	468	21.3	2953	23.3	119141	12.7
Female	214	9.6	1676	13.0	58990	6.1
Racial categories are non-Hispanic ** Data is suppressed due to counts under 10 or unreliable rates						

Overdoses have steeply risen over past years, primarily driven by opioid use and an increase in fentanyl. Those who are White and men are seeing the highest death rates. There are still several groups for whom we cannot track overdose death rates, including lesbian, gay, bisexual, and transgender individuals; current data collection must expand to include these categories.

MARIJUANA

The opioid epidemic in the United States has occupied a significant amount of community and health attention across the country, but other drugs like marijuana remain an important public health issue. Marijuana is the most commonly used illicit drug in the United States; in 2015, use in the past month had risen to over 22 million people (ages 12+) in 2015.³⁰ Between 2015-2016, nearly 13% of Kentucky residents over the age of 18 reported using marijuana at some point during the year (Figure 10).³¹ While the health effects differ from those of opioids, there are immense short and long-term health impacts such as inflammation of the airways and chronic bronchitis, declines in short-term memory, and effects on adolescent brains which are still developing.³²



Figure 10
Kentucky Adult Marijuana Use Rate, 2015-2016

SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008, 2009, 2015, and 2016 (2008 and 2009 Data – Revised March 2012).

As the number of states that have legalized cannabis has steadily increased, public health messaging regarding cannabis will need to be responsive. Combatting the unintended consequences of wider cannabis use has especially been needed in states where recreational use has been legalized in addition to medicinal use, such as California and Colorado. If legal, the same public health protections that we use for tobacco and alcohol need to be applied, including: no driving under the influence, smoking regulations to protect from second-hand exposure, legal age limits, and safe packaging to prevent consumption by children.³³

TOBACCO

It is not surprising that Louisville's average adult smoking rate from 2013 to 2016 was 24.8%; this rate is well above the national average of 17.9%. For many years, Louisville was the home of Big Tobacco. Firms such as Brown and Williamson, Phillip Morris and Lorillard were major employers. The city was also surrounded by family farms whose cash crop was government subsidized tobacco.

SMOKING REMAINS THE NUMBER ONE CAUSE OF PREVENTABLE DEATH IN AMERICA TODAY.35

Each year smoking is responsible for more than 480,000 premature deaths in Americans age 35 and older.³⁶

More than 87% of lung cancer deaths, 61% of pulmonary disease deaths, and 32% of all deaths

from coronary heart disease are attributable to smoking and exposure to secondhand smoke.³⁴ More than 10 times as many Americans have died prematurely from cigarette smoking as have died in all the wars fought by the United Sates in its entire history.³⁸

The top three causes of death in Louisville from 2011-2015 –cancer, heart disease, and chronic lower respiratory disease –all have smoking as a common risk factor.³⁹ While Louisville and the United States have the same rate of heart disease death, Louisville has a much higher rate of cancer, making it our leading cause of death (Figure 11).⁴⁰

Top 3 Causes of Death in Louisville, KY

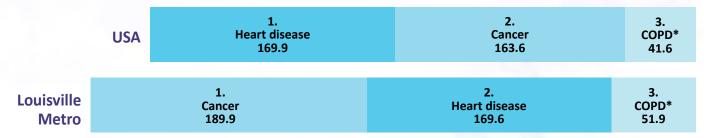


Figure 11
Top 3 Causes of Death in Louisville, KY

Louisville Metro Center for Health Equity: Health Equity Report 2011-2015 National Vital Statistics System, National Center for Health Statistics, CDC Age-adjusted to 2000 U.S. Standard Population, rates per 100,000.

*COPD or Chronic Obstructive Pulmonary Disease is now known as Chronic Lower Respiratory Disease.

According to the Behavioral Risk Factor Surveillance System (BRFSS), although the smoking prevalence has been declining both in Louisville and nationwide, the smoking prevalence of Louisville is consistently higher than the nation by 7% (Figure 12).⁴¹

The same survey found a higher rate of Black persons who smoke than White persons, as well as higher rates of male smokers than female smokers (Figure 13).⁴² This can give public health officials ideas of where and how to target prevention and cessation efforts.

Figure 12
Percent of Adults Who Are
Current Smokers, 2013-2016

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Jan 09, 2018]. Retrieved from https://www.cdc.gov/brfss/brfssprevalence/.

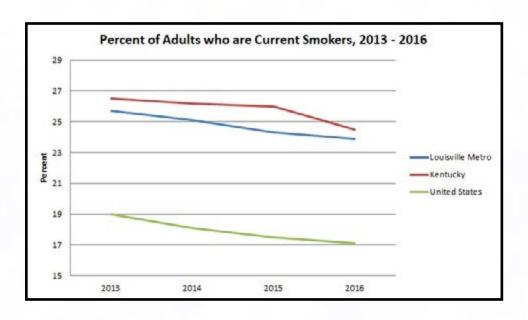


Figure 13
Average Percent of Current Adult
Smokers, 2013-2016

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Jan 09, 2018]. Retrieved from https://www.cdc.gov/brfss/brfssprevalence/.

Average Percent of Current Adult Smokers, 2013-2016				
	Louisville Metro Kentucky			
TOTAL	24.8	25.8		
White	23.3	25.6		
Black	28.9	25.6		
Hispanic	**	**		
Other	**	**		
Male	25.1	26.8		
Female	23.6	24.8		
Racial categories are non-Hispanic ** Data is suppressed due to counts under 10 or unreliable rates				

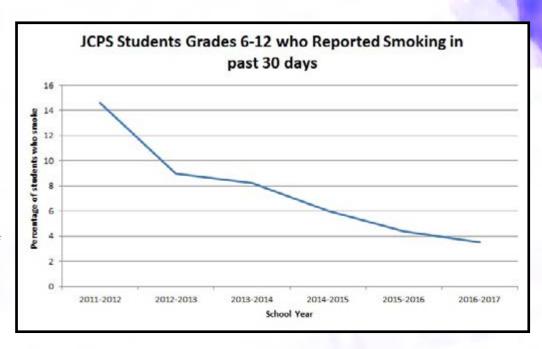
According to Jefferson County Public School's annual Safe and Drug Free Schools Survey, smoking has been declining among students from grades 6-12, although it refers only to cigarettes and is not inclusive of e-cigarettes (Figure 14).⁴³ Preventing starting smoking at younger ages can help reduce overall smoking rates. Additionally, evidence suggests that exposure to nicotine for junior high school students is connected to other drug use, including marijuana and/or cocaine, during the high school years.⁴⁴ Preventing the use of tobacco cannot only help young people from becoming regular cigarette smokers, but may help to prevent the use of other drugs in the future.⁴⁵

Figure 14

JCPS Students Grades 6-12 who
Reported Smoking in Past 30 Days

2011-2016, Safe and Drug Free Schools Survey, Jefferson County Public Schools

*Note: Survey question language was changed in 2013. Data based on the following questions: 2011-2012: How many occasions (if any) have you smoked cigarettes or used other tobacco products during the past 30 days?; 2013-2016: During the past 30 days did you smoke part or all of a cigarette?



According to the Centers for Disease Control and Prevention National Youth Tobacco Survey, the use of e-cigarettes among young people has surpassed the use of conventional cigarettes since 2011. ⁴⁶ The 2014 CDC survey found current usage rates of electronic cigarettes at 13.4% among high school students and 3.9% among middle school students. ⁴⁷ These compare to usage rates for conventional cigarettes of 9.2% among high school students and 2.5% among middle school students. ⁴⁸ Additional research is needed to understand the scope of the long-term health effects of e-cigarettes on users. While e-cigarettes release fewer harmful chemicals than traditional cigarettes, research shows that the aerosol from e-cigarettes can be harmful to your health. ⁴⁹

ALCOHOL

Alcohol use remains a serious problem in the United States. Government organizations like the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) continue to track the effects of alcohol on the public's health, which include heart disease, stroke and mental health issues.⁵⁰

The age-adjusted alcohol-induced death rates in Louisville Metro are consistently higher than state as well national rates. Louisville Metro had the highest age-adjusted death rate in 2015 at 12.8, compared to 7.6 in 2011. ⁵¹ While the rates were still climbing from 2015 to 2016 in Kentucky and nationwide, the Louisville Metro rates declined by 1.6 deaths per 100,000 population (Figure 15). ⁵²

During 2011-2016, the non-Hispanic White population had a higher alcohol-induced death rate than the non-Hispanic Black population, and males had a higher rate than females (Figure 16).⁵³

Figure 15
Alcohol-Induced Death Rates, 2011-2016

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

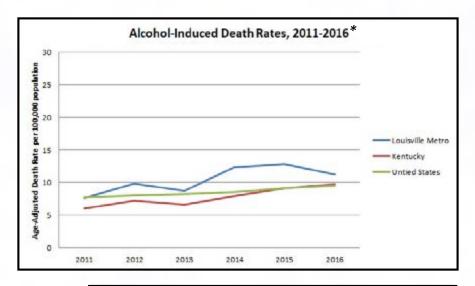


Figure 16Alcohol Induced Death Rates by Race and Sex, 2011-2016

Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Alcohol Induced Death Rates by Race and Sex, 2011-2016*						
	Louisville Metro		Kentucky		United States	
	COUNTS	RATES	COUNTS	RATES	COUNTS	RATES
TOTAL	539	10.5	2337	7.8	182175	8.5
White	448	11.8	2136	8.0	132753	8.9
Black	87	8.6	163	7.4	15754	6.4
Hispanic	**	**	25	4.3	23968	9.4
Other	**	**	13	**	8536	6.4
Male	396	16.3	1798	12.3	132877	12.8
Female	143	5.4	539	3.6	49298	4.6
*Racial categories are non-Hispanic						

^{**} Data is suppressed due to counts under 10 or unreliable rates

^{*} Age-adjusted

^{*} Age-adjusted

Binge drinking occurs throughout Louisville with heavier pockets in university areas and in the east and southeast portions of the county (Figure 18).⁵⁴

From January 2015 through June 2017 there were alcohol related hospitalizations in every single ZIP code in Louisville, with heavier concentrations in the west and southwest (Figure 18). 55

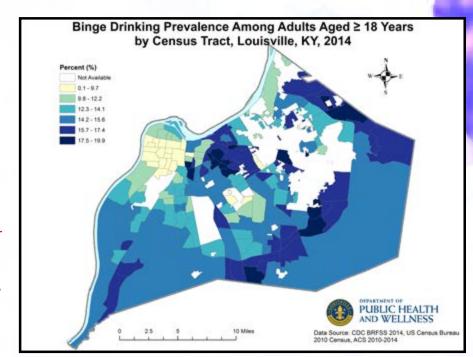


Figure 17

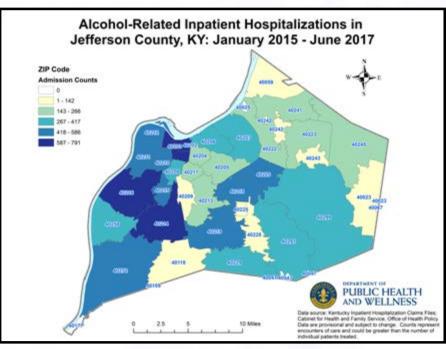
Binge Drinking Prevalence Among Adults Aged ≥ 18 Years by Census Tract, Louisville, KY 2014

500 Cities Project: Local Data for Better Health 2014. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Available from: https://www.cdc. gov/500cities/about.htm



Alcohol-Related Inpatient Hospitalizations in Jefferson County, KY, January 2015-June 2017

Kentucky Inpatient Hospitalization Claims Files; Cabinet for Health and Family Service, Office of Health Policy. Data are provisional and subject to change. Counts represent encounters of care and could be greater than the number of individual patients treated.



ROOT CAUSES

As detailed in the Louisville Metro Department of Public Health and Wellness 2017 Health Equity Report, to improve population health, it is important to understand the root causes behind them. Root causes impact health outcomes because the way an individual experiences a root cause often provides either an advantage (such as higher income or more access to resources to cope with stress and adversity) or a disadvantage (such as lower income and higher life stressors). These root causes create environments with specific choices; the choices that residents make are shaped by the choices that are available to them.

Root causes can influence the likelihood that someone may begin using substances, what kinds of treatment they may be able to access, and how likely they are to successfully recover. Addressing root causes can ensure that people are less likely to begin using substances and more likely to recover. An examination of root causes is critical to finding long-term, systemic solutions.

These sections address some of the root causes that may contribute to whether an individual begins using harmful substances or develops a substance use disorder, and whether they can successfully recover. This is not an all-inclusive list, but rather a general overview of some of the top root causes.



EARLY CHILDHOOD DEVELOPMENT

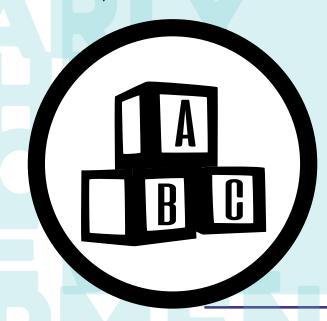
The World Health Organization (WHO) defines early childhood as the period of life that includes prenatal to age eight. ⁵⁶ This time period is crucial to health and wellbeing across the life course, due to rapid brain development and exposure to environments and experiences that can help or hinder healthy growth. ⁵⁷

Child development is a function of both genetics and the environmental exposures that impact a person from before they are born and as they grow. A mother's use of illicit drugs, tobacco or alcohol during pregnancy can have adverse effects on her baby's brain development. The incidence rate of Neonatal Abstinence Syndrome (NAS) in Kentucky is one of the highest in the nation; Louisville is among the top 3 counties with reported NAS cases in Kentucky. Early identification of women who use substances before and during pregnancy is critical to providing appropriate health services and treatment referrals.

Substance use disorder and the opioid epidemic are impacting children and families in significant ways. Nationally, the number of children entering the foster care system has increased over the past several years; between 2012 and 2015, there was a 13% increase in the number of cases that identified parental substance use as the reason a child was removed from their home. In Kentucky, the number of children in out-of-home-care rose by 17% from June 2011 to June 2016.

During their early years, children need safe and nurturing environments to ensure they develop the skills to learn, understand, reason and remember as well as to regulate their emotions and participate in healthy relationships. ⁶² Exposure to abuse and/or neglect in early childhood can negatively impact development, causing difficulties with learning, regulation of emotions, and social skills.

Long term, early exposure to childhood adversity can lead to trauma that negatively impacts health and quality of life well into adulthood. Adverse childhood experiences (ACEs) have been shown to be associated with an increased risk for depression and suicide, sexual promiscuity, smoking, illicit drug use (including intravenous drug injection) and alcoholism in adulthood. Early trauma and addiction later in life are strongly related. Early trauma and addiction later in life are strongly related.



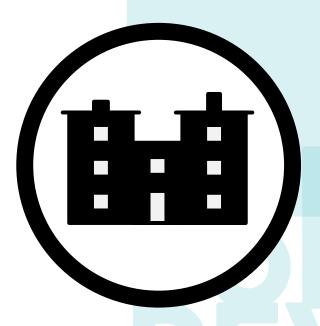
The child's primary environment and source of experience is their family. Parents and caregivers— especially those who have a history of ACEs or other traumas—can learn skills and access resources to help them provide healthy developmental supports. Families can build resilience in their own homes when they understand the critical importance of early childhood experiences, identify their own ACEs and implement strategies to nurture their children. Strategies for strengthening families in these ways include home visitation programs, which ensure access to prenatal health care, resources for basic needs like food and shelter, education about caring for infants, and skill building for developmental discipline and stress management.

NEIGHBORHOOD DEVELOPMENT

Neighborhood development examines the economic and social characteristics of a neighborhood and how they came to exist. Not only does this root cause consider what type of business and developments are happening but it also examines the type of zoning laws and development decisions that shape the resources of the community. Laws that allow greater development and marketing of cigarettes and alcohol to vulnerable communities can have negative impacts on those neighborhoods and can increase the risk of members of those vulnerable communities developing substance use disorder.

Research shows that the alcohol outlet density of a neighborhood, determined by licensing and zoning, is related to alcohol use and violence. High alcohol outlet density, defined as having a high concentration of retail alcohol outlets in a small area, is an environmental risk factor for excessive drinking. Additionally, one study found that when all other factors were controlled, higher initial levels of drinking and excessive drinking were observed among youths residing in ZIP codes with higher alcohol outlet densities.⁶⁵

Kentucky has a long history with tobacco and alcohol use and there are many decades of research showing patterns of strategic marketing to lower income communities and communities of color, in particular Black communities, through point-of-sale marketing. Point-of-sale marketing includes locating signage promoting cigarettes and alcohol near the check out.⁶⁶ Research shows there is a significant impact on smoking behaviors when tobacco companies target advertising toward



low income neighborhoods.⁶⁷ For example, because lower income communities have a higher density of convenience stores primarily marketing and selling alcohol and tobacco products, residents have more access to tobacco products than to fresh foods or full service grocers. For those who do not smoke, neighborhoods with high rates of smoking can also impact their health through increased secondhand smoke exposure.⁶⁸

Research suggests that having laws that protect vulnerable communities from high alcohol outlet density and targeted marketing would help to reduce substance use and violence in those neighborhoods.⁶⁹

HEALTH AND HUMAN SERVICES

Having access to comprehensive, integrated healthcare services can be a key factor in whether someone develops and/or successfully receives treatment for substance use disorder. The National Bureau of Economic Research (NBER) reports that there is a "definite connection between mental illness and the use of addictive substances." Often, a person with a mental health issue such as anxiety, depression, bi-polar disorder, or schizophrenia will turn to cigarettes, alcohol and illicit drugs, because they find it helps them cope or relieve symptoms of mental illness. Unfortunately, excessive substance use brought on by addiction can trigger mental health symptoms creating a cycle that may be difficult to treat.

Expanding access to mental healthcare can ensure that residents are able to develop healthy coping skills and effectively address trauma and underlying mental health issues before developing substance use disorder. Additionally, ensuring that integrated services, which simultaneously treat mental health and substance use disorders, are available and reimbursable will improve success of treatment.

Other factors, such as having health insurance and the ability to pay for care, proximity to health care services, and culturally-competent providers can impact a person's access to quality health and human services. 72,73

Research results reveal a positive impact on uninsured individuals when they access affordable coverage; after gaining health insurance, these individuals are more likely to successfully quit

smoking.⁷⁴ Because those with lower incomes are more likely to both be uninsured and use tobacco, these results identify a long-term impact of access to healthcare services for those with the greatest need and the least structural support.

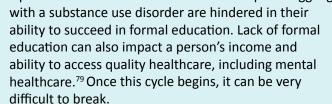


EDUCATION

Substance use disorders can impact anyone, regardless of their level of formal education. However, research shows a connection between limited levels of education, such as not receiving a high school diploma, and high rates of substance use.⁷⁵ This doesn't mean you're more susceptible to developing a substance use disorder if you don't finish high school, or don't go to college. Instead, this reveals that formal education has a greater potential to provide protection against risk factors that can lead to substance use, through things like steady employment, which may then lead to steady income, housing, healthcare, transportation, and access to healthy food.⁷⁶

For students living in or around poverty, educational attainment in under-resourced schools becomes all the more difficult.⁷⁷ Along with the many consequences of not being able to afford basic needs, children living in poverty can potentially be at a greater risk for substance use disorders because of school conditions beyond their control, such as unqualified teachers, few exploratory courses, or limited technology. Additionally, seeing the stark differences between their quality of life and that of students with a stable income can negatively impact how they envision their future.⁷⁸

The interrelationship between education and substance use means that education level can impact substance use, which in turn can impact future educational attainment. People struggling



Educational systems are also opportunities to engage youth in leadership development opportunities and extracurricular programs; they can learn such important skills as positive self-expression, social-emotional learning, problem solving, and coping skills that provide protection against experimenting with and using substances such as illicit drugs, tobacco, and alcohol.



HOUSING

The Substance Abuse and Mental Health Services Administration (SAMSHA) recognizes the linkage between substance use disorder and homelessness and vice versa.⁸⁰ When a person is homeless, they are more likely to use substances than someone with stable housing.⁸¹ People need to have their basic needs met—including housing—before they can address behavioral health, substance use disorders, chronic illnesses and other barriers to a stable life⁸².



Persons who are homeless and living with an addiction have been deemed "one of the most vulnerable populations." Undeniably, substance use disorder may be one factor leading to homelessness; however, substance use may also be the result of coping with homelessness—increasing the percentage of the population who become addicted to substances. The Office of National Drug Control

Policy states that of the chronically homeless population "30% have a serious mental illness and around two-thirds had a primary substance use disorder or other chronic health condition." Researchers state that there is a reduction of relapse when persons struggling with addiction have stable housing. ⁸⁵

Establishing stable housing and supports leads to increased security and can empower individuals. Successful supportive housing programs include social support, adaptable treatment selections, and services that lead to social reintegration. Housing is foundational to addressing substance use disorder, but housing alone is not sufficient to preventing or recovering from substance use disorder.⁸⁶

EMPLOYMENT AND INCOME



Anyone can develop a substance use disorder, but the financial resources an individual has—and whether they have stable employment—can directly affect their stress, the amount and type of drug they can access, as well as their ability to access healthcare. Higher income levels can provide people greater access to buying alcohol, tobacco, other substances, and buying them safely. Additionally, the income level of an individual with a substance use disorder may determine whether they are able to seek treatment. There is not a one-treatment-fits-all fix when it comes to addiction; some individuals may have to try multiple types of treatment before they discover the one that is right for them. Accessing and determining the right treatment can lead to extensive medical bills which someone with a smaller income may not be able to afford. Additionally, some insurance providers do not cover certain types of treatment, therefore, requiring the patient to pay out of pocket.

CRIMINAL JUSTICE

The criminal justice system is made up of the many linkages between courts, law enforcement, jails and prisons. This system is shaped by the laws that govern individuals at the local, state and federal levels, and determine what actions and behaviors are criminalized.

In 2013, nearly 1 in 35 adults in the United States were incarcerated at some level during the year; that equated to almost 6.9 million people.⁸⁹ The numbers of incarcerated people has grown significantly over the past few decades due in large part to sentencing patterns for substance-related charges and incarceration of people who use drugs.⁹⁰ Initiated in the 1980s, the War on Drugs has expanded the sentences for drug related charges to be nearly 3 times as long today.⁹¹

Substance use and addiction have an established connection to the criminal justice system. Incarcerated individuals have 4 times the rate of substance use and addiction as those who are not incarcerated. There can be significant health impacts for those who are involved with the criminal justice system, including: losing access to care for chronic health conditions, mental health issues, and exposure to other infectious diseases. Additionally, the impact of involvement with the criminal justice system creates other issues for people, including barriers to housing and employment—additional root causes of health. Providing supports and greater access to the expungement process can help to alleviate these barriers by removing some offenses from a person's record.

Other impacts on individuals extend to their families and communities, and can especially be felt by children. 96 Research shows that having at least one parent jailed during pregnancy



(regardless of if it is the mother or father), plays an important role in the health outcomes for newborn children.⁹⁷ This means that those with substance use disorder can often have compounding negative consequences, making their treatment and recovery more difficult. Laws and policies focused on decriminalization and diversion can simplify the path to recovery.

TRANSPORTATION

Transportation looks at the ways that people are able to move through a community, whether by walking, biking, driving or taking public transportation. It examines what infrastructure exists and what kinds of transportation modes it supports. It also examines what kinds of laws or policies make the environment easier or more difficult to navigate.⁹⁸



Adequate transportation is an essential aspect of having access to services for the prevention and treatment of substance use disorders. For instance, if an individual does not own a car, they may be reliant on family and friends to juggle multiple schedules. The cost of regular public transportation can also be prohibitive to individuals with low incomes. Additionally, routes from one's home to a needed service may be long, requiring several transfers, and still may not get the person directly to where they need to go. ⁹⁹ Consistent and reliable forms of transportation are needed to get people to and from services and to help ensure successful prevention and treatment of substance use disorder. ¹⁰⁰

Impaired driving also has created safety issues within transportation systems resulting in serious consequences for families, workers, and community members. Alcohol and drugs are a factor in a significant percentage of transportation-related accidents each year; over a decade from 2003 to 2012, there were 2,041 deaths in Kentucky involving a driver who was intoxicated.¹⁰¹

SOCIAL/ CULTURAL CAPITAL

The social/cultural capital root cause examines the social norms and narratives surrounding substance use and what social support is available to help people with substance use disorder. How the media depicts substance use disorder in the newspaper, television or movies affects how we deal with the condition in our city,

community, families, and individually. These portrayals have led to negative messaging around substance use disorder, including depicting people with addiction as having a "moral failure", rather than acknowledging that they are dealing with a serious medical condition. Stigma can be reinforced by derogatory terms.

The effects of stigma are many; stigma can prevent people from seeking the help they need and lead to worse health outcomes because they are more likely to drop out of treatment. 102 Additionally, people can face worse care from health care providers who may not think they deserve treatment. Fear of losing, employment, social support, and housing can further prevent treatment. Overall, stigma can have a negative impact on persons with substance use disorder by preventing them from seeking care, and internalizing negative messaging. Stigma can also distract communities from evidence-based practices and may lead to misguided notions about with interventions will be most or least successful. 103 To improve outcomes for those with substance use disorder, we must change the predominate narrative.



Goals to Meet the Challenges of Substance Use Disorder in Louisville



Substance use disorder, like any other significant challenge our community faces, will take many of us working together in every part of our community and at every level. A comprehensive and effective strategy must reach across many sectors and areas of our community. Addressing this public health issue means we must aim to help people develop skills that allow them to avoid to substance use and addiction, deal with the immediate effects of substance use, and meet and overcome the challenges of the long-term effects and impacts of substance use disorder.

This plan makes specific recommendations for evidence-based best practices to address substance use disorder in Louisville over the next two years. Best practices are evidence-based interventions—including policy change—which have been applied in other localities and have proven to make a difference for health. The following goals span the levels of the socio-ecological model: public policy, community, organizational, interpersonal, and individual. We must include interventions at each of these levels in order to reinforce their impact, and make sustainable, long-term change.



TO REDUCE THE BURDEN OF SUBSTANCE USE DISORDER IN JEFFERSON COUNTY.





Prevent and Reduce Youth Substance Use

Establish a county-wide coalition in Louisville—representing at least 12 sectors impacting youth and their families—to develop a 12-month action plan to prevent and reduce youth substance use by September 2018. Apply for funding to implement the plan by 2020.







CHAMPION: One Love Louisville's Substance Use Workgroup

Increase Trauma Informed Care

Assess current initiatives in Louisville who have integrated resilience, traumainformed care, and Adverse Childhood Experiences (ACEs) screening into their work with young people ages 0-24 by July 2018. Identify opportunities for organizational collaboration and capacity building to integrate resilience, trauma-informed care, and ACEs screening across community programming by October 2018. Initiate training with 50% of Louisville's youth-serving organizations by March 2019.

CHAMPION: BOUNCE Coalition





Reduce Stigma

Develop a public health social media campaign for Louisville in collaboration with community organizations and residents to promote the understanding of substance use disorders, including the use of appropriate language around substance use by July 2019.

CHAMPION: Louisville Metro Department of Public Health & Wellness

ICON KEY:



ENVIRONMENT



EDUCATION



FOOD SYSTEMS



ENVIRONMENTAL QUALITY



HEALTH AND HUMAN SERVICES



HOUSING



CRIMINAL JUSTICE



EARLY CHILDHOOD DEVELOPMENT



TRANSPORTATION



AND INCOME



NEIGHBORHOOD DEVELOPMENT



SOCIAL/ **CULTURAL CAPITAL**





Increase Harm Reduction

Provide increased harm reduction by securing additional funding sources for syringe exchange mobile units, and naloxone availability and training for highest areas of drug use/overdose in the community (i.e., public spaces such as the library, TARC buses, government buildings, and businesses) by March 2019. Expand naloxone administration training to 20% more first responders, local law enforcement agencies, public safety agencies, and community organizations by July 2019. Provide at least three additional syringe exchange mobile sites for total of seven community sites by July 2019.

CHAMPIONS: Volunteers of America • Kentucky Harm Reduction Coalition

Expand Diversion From Emergency Rooms and Jail

Expand The Living Room array of services to create a 24/7 urgent behavioral health environment in order to improve connecting citizens in mental health, substance use disorder, or co-occurring crisis with immediate peer support, clinical triage and referral/connection to appropriate community resources by June 2018. Identify program funding by September 2018. Be fully operational by March 2019.



CHAMPION: Centerstone



Improve Connection to Treatment

Expand peer support to 24 hour coverage in emergency rooms in order to improve connecting patients with substance use disorder to treatment by June 2018. Identify program funding for Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment) by September 2018. Be fullly operational by March 2019.

CHAMPION: University of Louisville Hospital

Measure the Quality of Treatment Programs

Develop 10 quality metrics for substance use disorder treatment providers in Louisville to report, and a plan for how and when data will be shared by December 2020.

CHAMPION: University of Louisville School of Public Health and Information Science







Establish Guidelines for Sober Living Houses

Create and enact an ordinance providing necessary guidelines for sober living houses (aka "recovery residences") in the Louisville by Fall 2018.

ROOT CAUSES:



CHAMPIONS: Louisville Metro Office of Resilience • Treatment Advisory Group

Make Expungement Affordable

Expand recovery support to increase access to housing and employment by modifying existing legislation in Kentucky Revised Statute to make expungement easier and more affordable, including: automatic expungement after 30 days for dismissed misdemeanors, dismissed felonies, and acquittals by February 2019.

CHAMPION: Louisville Urban League





ROOT CAUSES:



Improve Job Placement

Establish a taskforce to determine how best to connect people in recovery to quality employment in Louisville by September 2018. Expand the number of employers hiring people in recovery by 10% by October of 2019.

CHAMPIONS: KentuckianaWorks • Louisville Metro Department of Public Health & Wellness

Additional Recommendations for Our Community

The work of addressing substance use disorders in Louisville needs many champions! Which work will you be part of?

PUBLIC POLICY

national, state, local law Connect with your elected officials!

COMMUNITY

relationships among organizations How can we link resources together?

ORGANIZATIONAL

organizations, social institutions Change where you work, learn, pray, and play.

INTERPERSONAL

family, friends, social networks
Support each other!

INDIVIDUAL

knowledge, attitudes, skills What you can do!

Here we include additional recommendations brought forward by knowledgeable, compassionate, and skilled practitioners and other experts in our community during this plan development process. These recommendations span the levels of the socio-ecological model: public policy, community, organizational, interpersonal, and individual. We must include interventions at each of these levels in order to reinforce their impact, and make sustainable, long-term change. See the references section of this report for more information about these recommendations.

HOPE

Public Policy—shaping national, state, local law



Increase the age of sale for tobacco products from 18 to 21. 104



Restrict marketing/sales of alcohol, controlled substances and tobacco. 105



Limit density of liquor and tobacco stores. 106



Increase the tax on tobacco and alcohol products to reduce demand and consumption and prevent youth from starting. 107



Implement childcare subsidies to help parents with low-income work more hours, stay in jobs longer and increase overall earnings. 108



Implement Paid Parental Leave Policies for working parents. An improvement in overall and mental health has been demonstrated when leave is paid.¹⁰⁹



Implement a state-level Earned Income Tax Credit (EITC) to aid wealth building and alleviate poverty. 110



Continue to develop, monitor, and enforce controlled substance prescription tracking through out Kentucky All Scheduled Prescription Electronic Reporting system (KASPER).¹¹¹

Community—linking resources and building relationships among organizations



Implement Youth in Europe Model. Proven, replicated model that has reduced substance use in Iceland and across Europe in adolescents from 40+% to 3%. 112



Expand existing resiliency programs including BOUNCE, Compassionate Schools Program, and home visitation programs such as HANDS, Healthy Start, and potential future implementation of Parents as Teachers home visitation program. ¹¹³



Continue to educate providers on prescribing practices for opioids, outlining Centers for Disease Control recommendations, and advising prescribers of existing education opportunities.¹¹⁴



Enforce prohibition of tobacco and alcohol sales to minors. 115

Organizational—the changes organizations and social institutions can make



Create worksite well-being through evidence-based programs that reduce behaviors risk in work settings. 116



Promote safe drug disposal in conjunction with retail pharmacy through distribution of disposal bags, take-home chemical destruction kits, and/or increased take-back sites. 117

Interpersonal—coming together to support our friends and family

Tell those you know, love, and care about that they can come to you for support and help if they are struggling. 118

Individual—what you can do

Learn which coping and stress management skills work for you; this may include therapy. There are many resources online; search using terms "stress management" and "self-care." 119

Learn and practice stress management skills that work for you: exercise, dance, music, art, spiritual connection, talking things out with a friend, writing in a journal.¹²⁰

Keep prescription medications out of reach of others, and don't keep them in your medicine cabinet when no longer needed.



HEALING

Public Policy—shaping national, state, local law



Advocate for state regulation to allow safe/supervised injection sites based on other urban models. (e.g., San Francisco, Philadelphia). 121



Strengthen supports for public housing providers to avoid eviction when residents are amenable to treatment for substance use disorder.¹²²





Advocate for incarcerated individuals to keep their health insurance while in iail.¹²³





Expand medication-assisted treatment (MAT) services by enforcing ordinance that facilities with MAT cannot be treated in a discriminatory manner with respect to real estate. 124



Promote and finance two-generation, family-centered treatment and support for children under foster and kinship care. 125

Community—linking resources and building relationships among organizations



Implement quick response teams (QRTs) with LMPD, EMS, social services, and substance use disorder professionals in high risk Zip codes. 126



Expand medication-assisted treatment (MAT) services by expanding providers initiating MAT in emergency departments or at hospital discharge. ¹²⁷



Promote www.findhelpnowky.org, a real-time substance use disorder treatment availability locator and information center for Kentucky. The locator contains treatment providers and treatment openings across the Commonwealth of Kentucky including community mental health centers; private, non-profit, and faith-based treatment providers; and providers of medication-assisted treatment.





Advocate for improved mental health and medical services for people who are incarcerated. 128

Organizational—the changes organizations and social institutions can make



Implement culturally competent care and treatment models to serve the diverse communities in our city. 129



Expand medication-assisted treatment (MAT) services by developing substance use disorder consultation services at all major hospital systems in Louisville.¹³⁰

Interpersonal—coming together to support our friends and family

Learn how to best support someone who is struggling and help connect them to resources.

Individual—what you can do

Attend a local Naloxone administration training.

Find assistance at treatment and help centers in Kentucky.



RECOVERY

Public Policy—shaping national, state, local law



Increase funding for the Louisville Affordable Housing Trust Fund and home improvement loans and grants to help generate a greater inventory of healthy, affordable housing for low-income residents.¹³¹





Utilize Medicaid to reimburse supportive housing programs that co-locate employment, education, and health services. 132



Support efforts to decriminalize the possession and use of illicit drugs to shift from a punitive model to a treatment model. 133

Community—linking resources and building relationships among organizations



Broaden public health-based approaches to rebuild workforce capacity among victims of past drug epidemics.¹³⁴



Extend the benefits of public health-based interventions to individuals who were burdened by criminal justice rather than public health approaches to the disease of addiction during America's earlier opioid crisis.¹³⁵

Organizational—the changes organizations and social institutions can make

Be an advocate for employees by promoting prevention, early intervention, treatment, and recovery. 136



Interpersonal—coming together to support our friends and family

Cultivate strong relationships so that you are able to support each other.

Individual—what you can do

Seek therapy for mental health issues and for unresolved traumatic events in your life.

Find a local support network that helps you keep on the path to recovery.





BOUNCE COALITION - BOUNCE endeavors to improve the future health of children in Louisville, fostering the skills to bounce back from adversity with resiliency and grit through the collaboration of diverse community partners. The BOUNCE Coalition is comprised of leaders from 17 collaborating organizations which are committed to planning and implementing evidence-based initiatives that promote child well-being, impact local systems and policies to reduce risks for chronic diseases, and help youth practice healthy behaviors.

BRICC COALITION - University of Louisville's Building Resilience in Campus Community (BRICC) Coalition's efforts to increase resilience and reduce high-risk drinking target individual, group, organization and community levels.

CALL TO ACTION (CTA) TASK FORCE - This group was convened by a small group of residents in the summer of 2017 in response to the release of the report called "A Call to Action: Louisville Heroin and Opioid Response Summit" by US Attorney, John Kuhn, Jr. The CTA Task Force is a citizen-driven, independent, volunteer, and non-political group with an overarching goal to develop a strategic plan based on the key objectives identified in the report.

DRUG ENFORCEMENT AGENCY (DEA) 360 TASK FORCE - Coordinated law enforcement operations targeting all levels of drug trafficking organizations, engaging drug manufacturers, wholesalers, practitioners, and pharmacists through diversion control to increase awareness of the opioid epidemic and encourage responsible prescribing practices, and community outreach and partnership with local organizations following enforcement operations. This group culminated in the report, "A Call to Action."

DUAL DIAGNOSIS CROSS-FUNCTIONAL TEAM (DDCFT) - This group was convened by Mayor Fischer in January 2013 to improve the system response to individuals with co-occurring mental health and substance use disorders who revolve in and out of jail, community treatment, hospitals and emergency rooms. The DDCFT brings together external community partners and local government to share information and discuss systemic solutions specifically related to the varied needs of this population. An outcome of the Dual Diagnosis Cross-Functional Team, is the Law Enforcement Assisted Diversion (LEAD) which offers treatment access before the offender is booked rather than being charged and arrested for non-violent drug crimes. The LEAD pilot will begin in 2018.

KENTUCKY HARM REDUCTION COALITION • THE LOUISVILLE SYRINGE EXCHANGE PROGRAM (SEP) • UNIVERSITY OF LOUISVILLE PHARMACY

- At least twice a month the Kentucky Harm Reduction Coalition provides free overdose prevention training to syringe exchange participants and their family members. In between, SEP participants are given a naloxone voucher they can take to the University of Louisville Pharmacy to receive free naloxone and training.

LOUISVILLE METRO CORRECTIONS (LMC) AND LOCAL TREATMENT PROVIDERS - When inmates are discharged they may request the Vivitrol shot. LMC connects them with local treatment providers to continue treatment. (Vivitrol is a monthly injection which blocks opioid receptors in the brain).

LOUISVILLE METRO CORRECTIONS • LOUISVILLE METRO DEPARTMENT OF PUBLIC HEALTH AND WELLNESS' MORE CENTER - Provides medication-assisted treatment and therapy to pregnant inmates.

• VOLUNTEERS OF AMERICA (VOA) - These agencies partner together to operate Louisville's syringe exchange program, a proven practice to stop the spread of HIV and blood borne diseases. VOA works with LMPHW to operate four community syringe exchange locations. Since it began in 2015, Louisville's syringe exchange program has served more than 14,000 participants.

LOUISVILLE URBAN LEAGUE AND THE REILY REENTRY PROJECT - The project is designed to assist Louisville Urban League clients and others seeking to expunge their record. The project facilitates the expungement process and covers most, if not all, related fees at no expense. Participants can enroll in any League program that will equip them with the tools they need to be more successful as they move into more prosperous futures.

ONE LOVE LOUISVILLE SUBSTANCE USE PREVENTION GROUP - One Love Louisville is a comprehensive strategy to reduce overdose, suicide and homicide rates. This group has worked over the past 2 years in small work groups focused on family support, treatment, and prevention in the community.

SAFE MEDICATION DISPOSAL - Safely disposing of prescription medications helps to reduce the chances of accidental ingestion or intentional misuse. Many people who misuse medications, such as opioids, get their first dose by using medications prescribed to other people. Many Louisville agencies collaborate to ensure the safe disposal of prescription medication by hosting regular "Drug Take Back" Days or by offering year round safe disposal options. Those agencies include U.S. Drug Enforcement Office Louisville Division, Walgreens, CVS Pharmacy, Louisville Metro Police, City of St. Matthews, and the Jefferson County Sheriff's Office. - Visit https://www.lojic.org/safe-medication-disposal-locations for map.

THE LIVING ROOM - A voluntary, peer-operated safe and calming space for adults in crisis. Centerstone hopes to divert up to 90% of people in crisis from jail, the emergency room, or inpatient hospitalization. The program is open 24 hours a day, seven days a week. Services provided include peer support, referrals to community resources and treatment programs, and health and vital checks. This program is run in collaboration with the Louisville Metro Police Department and the Louisville Metro Department of Corrections.

THE SAFE CITY ROUNDTABLE - Local officials and citizen leaders whose current mission is to decriminalize mental illness and addiction in Louisville. The Roundtable's long-term goal is to support a shift of community resources to place more emphasis on prevention and treatment, and less emphasis on law enforcement and corrections. The guiding philosophy of the Roundtable is that mental illness and addiction are first and foremost health problems, rather than criminal justice problems. Organizations involved in the Safe City Roundtable include: University of Louisville School of Public Health & Information Sciences, Jefferson County Attorney, Centerstone, Metro Council, Metro Corrections, Jefferson County Public Schools, Jefferson District Court, Louisville Metro Police, CLOUT, Volunteers of America and the Louisville Metro Department of Public Health and Wellness.

TREATMENT ADVISORY GROUP (TAG) - This group is comprised of providers from every treatment approach who convene monthly to facilitate collaboration among local treatment providers and remove barriers to treatment. Additionally, TAG reaches out to new treatment providers as they open for business within the city. Along with their monthly meeting, TAG is working with many initiatives to improve treatment and recovery in Louisville.

YOUNG PEOPLE IN RECOVERY, KENTUCKY HARM REDUCTION

COALITION - Partner monthly and on an on-call basis to do safe disposal of discarded syringes up in parks and areas that have been identified as high areas of injection drug use.

APPENDICES

CHANGING THE CONVERSATION

Replace stigmatizing words with more neutral language

INSTEAD OF:	TRY:
ADDICT	Person with a substance use disorder • Person with a serious substance use disorder
ADDICTED to X	Has an X use disorder • Has a serious X use disorder • Has a substance disorder involving X (If more than one substance is involved)
ADDICTION	Substance use disorder • Serious substance use disorder NOTE: • "Addiction" is appropriate when quoting findings or research that used the term or if it appears in a proper name of an organization. • "Addiction" is appropriate when speaking of the disease process that leads to someone developing a substance use disorder that includes compulsive use (for example 'the field of addiction medicine,' and 'the science of addiction').• It is appropriate to refer to scheduled drugs as "addictive."
ALCOHOLIC	Person with an acohol use disorder • Person with a serious alcohol use disorder
ALCOHOLICS ANONYMOUS/ NARCOTICS ANONYMOUS/ ETC.	NOTE: When using these terms, take care to avoid divulging an individual's participation in a named 12- step program
CLEAN	Abstinent
CLEAN SCREEN	Substance-free • Testing negative for substance use
DIRTY	Actively using • Positive for substance use
DIRTY SCREEN	Testing positive for substance use
DRUG HABIT	Substance use disorder • Compulsive or regular substance use
DRUG/ SUBSTANCE ABUSER	Person with a substance use disorder • Person who uses drugs (if not qualified as a disorder) NOTE: When feasible, "Drug/Substance Abuse" can be replaced with "Substance Use Disorder."
FORMER/ REFORMED ADDICT/ ALCOHOLIC	Person in recovery • Person in long-term recovery
OPIOD REPLACEMENT OR METHADONE MAINTENANCE	Medication assisted treatment • Medication-assisted recovery
RECREATIONAL CASUAL OR EXPERIMENTAL USERS (AS OPPOSED TO THOSE WITH A USE DISORDER)	People who use drugs for non-medical reasons • People starting to use drugs • People who are new to drug use • Initiates

Source: White House Office of National Drug Control Policy

GLOSSARY

Addiction: A stigmatized word for the most severe form of substance use disorder, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.¹³⁷

Adverse Childhood Experiences (ACEs): ACEs are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.¹³⁸

Age-adjusted: Age-adjusted rates (as opposed to crude rates) are those that have taken into account the population's age distribution and corrected the data accordingly. This allows data to be comparable from place to place.

Alcohol: Ethyl alcohol, or ethanol, is an intoxicating ingredient found in beer, wine and liquor. Alcohol is produced by the fermentation of yeast, sugars, and starches. 139

Alcohol Use Disorder: Excessive drinking can put a person at risk of developing an alcohol use disorder. To be diagnosed with an alcohol use disorder, individuals must meet certain diagnostic criteria including: problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms.¹⁴⁰

Binge Drinking: Binge drinking for men is drinking 5 or more standard alcoholic drinks, and for women, 4 or more standard alcoholic drinks on the same occasion on at least 1 day in the past 30 days. ¹⁴¹

Controlled Substances: Controlled substances are drugs that are regulated by state and federal laws that aim to control the harmful effects of substance use disorders, physical and mental harm, the trafficking by illegal means, and the dangers from actions of those who have used the substances. Such drugs may be declared illegal for sale or use, but may be dispensed under a physician's prescription.¹⁴²

Expungement: Expungement is a court-ordered process in which the legal record of an arrest or a criminal conviction is "sealed," or erased in the eyes of the law. The availability of expungement, and the procedure for getting an arrest or conviction expunged, will vary according to the state or county in which the arrest or conviction occurred. ¹⁴³

Fentanyl: Fentanyl is a powerful synthetic drug that is similar to morphine and heroin but is 50 to 100 times more potent.

Heroin: Heroin is an opioid drug made from morphine, a natural substance taken from the seed pod of the various opium poppy plants. Heroin looks like a white or brownish powder, or as the black sticky substance known on the streets as "black tar heroin." A heroin overdose causes slow and shallow breathing, blue lips and fingernails, clammy skin, convulsions, coma, and can be fatal.¹⁴⁴

Medication Assisted Treatment: Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.¹⁴⁵

Naloxone: Naloxone is a medication used to treat a narcotic overdose in an emergency situation. It blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness.

Narcotics: "Narcotic" refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is "opioid." Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin®, Vicodin®, codeine, morphine, methadone, and fentanyl. 146

Neonatal Abstinence Syndrome: The collection of symptoms babies experience in withdrawing from drugs they were chronically exposed to in utero.¹⁴⁷

Opioids: Opioids are a class of drugs chemically similar to alkaloids found in opium poppies. Historically they have been used as painkillers, but they also have great potential for misuse.

Opioid Use Disorder: Repeated use of opioids greatly increases the risk of developing an opioid use disorder. The use of illegal opiate drugs such as heroin and the misuse of legally available pain relievers such as oxycodone and hydrocodone can have serious negative health effects. 148

Rate: The rate is the number of persons affected by the health outcome divided by the total number of people who could potentially be affected. Often death rates are per 100,000 and other rates are per 1,000.

Recovery-Oriented Systems of Care (ROSC): is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of alcohol and drug problems.¹⁴⁹

Sober living houses: Sober living homes are group homes that are free of alcohol and drugs for individuals in recovery. They operate like a co-op, where individuals contribute to the upkeep of the house through rent and chores.

Substance Abuse: A stigmatized phrase used to describe substance use disorders. See Substance Use Disorders.

Substance Misuse: The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).¹⁵⁰

Substance Use Disorders: Substance use disorders occur when the repeated use of alcohol and/or drugs causes significant problems in a person's life. These problems can occur with individual health, at school, work, or at home, using alcohol or drugs even when you would rather not, and taking risks that can lead to injury, traumatic events, or even death. Not everyone who uses substances, such as alcohol or drugs, will develop a substance use disorder, but for those who do, the American Psychiatric Association recognizes that "changes in the brain's wiring" occur, along with the development of "intense cravings," making it incredibly difficult to stop using the substances.¹⁵¹

Tobacco: Tobacco use may be defined as any habitual use of the tobacco plant leaf and its products. The predominant use of tobacco is by smoke inhalation of cigarettes, pipes, and cigars. Smokeless tobacco refers to a variety of tobacco products that are sniffed, sucked, or chewed.¹⁵²

Tobacco Use Disorder: More than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.¹⁵³

Vaping: Vaping is the act of inhaling and exhaling the aerosol, often referred to as vapor, which is produced by an e-cigarette or similar device. The term is used because e-cigarettes do not produce tobacco smoke, but rather an aerosol, often mistaken for water vapor, that actually consists of fine particles. Many of these particles contain varying amounts of toxic chemicals, which have been linked to cancer, as well as respiratory and heart disease. 154

HISTORY AND BACKGROUND OF U.S. DRUG ENFORCEMENT

LATE 19TH CENTURY TO EARLY 20TH CENTURY

Medicinal and recreational drug use in the United States dates to the country's inception. In the 1890s, the popular Sears and Roebuck catalogue advertised a syringe and small amount of cocaine for \$1.50. At that time, there were no federal government agencies regulating medical and pharmaceutical practice. Doctors often prescribed cocaine and morphine as pain treatments, and by the end of the 19th century, misuse of these substances had become significant and a matter of growing public concern.¹⁵⁵

To address the burgeoning levels of drug use in the country, the federal government attempted to regulate and control drugs through taxation. In some states, laws banning or regulating drugs were passed in the 1800s. The first congressional act to levy taxes on morphine and opium passed in 1890. It was not until the early 20th century that federal control of drugs gained traction. 156

The 1909 Smoking Opium Exclusion Act banned the possession, importation and use of opium for smoking. However, opium could still be used as a medication. This was the first federal law to ban the non-medical use of a substance.

In 1914, Congress passed the Harrison Act, which regulated and taxed the production, importation, and distribution of opiates and cocaine.

Alcohol prohibition laws quickly followed. In 1919, the 18th Amendment was ratified, banning the manufacture, transportation or sale of intoxicating liquors, and ushering in the Prohibition Era. In the same year, Congress passed the National Prohibition Act, which offered guidelines on how to federally enforce Prohibition.

Prohibition lasted until December, 1933, when the 21st Amendment was ratified, overturning the 18th.

Narcotic enforcement in the 1920s was closely tied to the enforcement of Prohibition. In 1930, responsibility for Prohibition enforcement was transferred to the Department of Justice. A new federal agency, the Federal Bureau of Narcotics (FBN) was established within the U.S. Treasury to oversee narcotic enforcement.

During the era of Prohibition, marijuana fast grew in popularity as a new recreational drug. At the end of Prohibition, controlling marijuana use became a focus of Congress and the FBN. The growth and use of marijuana was legal under state and federal law until 1937. The federal government unofficially banned marijuana under the Marihuana Tax Act of 1937. The Act did

not itself criminalize the possession or usage of hemp, marijuana, or cannabis. But included penalty and enforcement provisions to which marijuana, cannabis, or hemp handlers were subject. Violation of these procedures could result in a fine of up to \$2000 and five years' imprisonment. Shortly after passing the Marihuana Tax Act, all states made marijuana possession illegal.¹⁵⁷

MID-20TH CENTURY

After the Second World War, opioids – synthetic opiates – began to enter the market in greater numbers. These included drugs formulated using Hydrocodone (later popularized in the 1970s as the narcotic in Vicodin) and Oxycodone (the opiate best known today as an ingredient in OxyContin). Many doctors – knowing the risks of addiction and dependence – embraced a sort of "opiophobia", which caused them to shy away from prescribing pain pills frequently.¹⁵⁸

Over the next few decades, Congress continued to pass legislation to control drug misuse and further criminalized drug use. Examples of such legislation include the 1951 Boggs Act, which created mandatory prison sentences for some drug offenses and the 1956 Narcotic Control Act, which further increased penalties for drug offenses and made the death penalty a punishment for selling heroin to youth.

Federal support for a medical approach to drug misuse then became popular. For example, methadone became an acceptable and often used treatment for heroin dependence. Congress also promoted a medical approach to addressing drug use, stating its support for rehabilitation through treatment in the Narcotic Addict Rehabilitation Act.¹⁵⁹

In addition to an emphasis on the medical approach to preventing and responding to drug misuse there was a heavy emphasis on law enforcement. In 1969, President Nixon would respond to the rise of illicit drug use, especially heroin, by making the reduction of drug misuse a top priority.¹⁶⁰

The 1970s War on Drugs and the Controlled Substances Act

In June 1971, President Richard M. Nixon officially declared a "War on Drugs," stating that drug use was "public enemy number one." President Nixon's war on drugs placed greater emphasis on law enforcement. He sought greater federal control of drugs and pushed for passage of comprehensive federal drug laws. The Controlled Substance Act (CSA) put select plants, drugs and chemical substances under federal jurisdiction and created a statutory framework for the federal government to regulate lawful production, possession and distribution of controlled substances.¹⁶¹

In July 1973, Nixon authorized creation of a federal agency to enforce the CSA - the Drug Enforcement Administration (DEA). Later that year, the DEA was place under control of the

Department of Justice (DOJ). The Nixon administration highlighted the importance of the DEA's role in gaining cooperation and coordination among the DEA, the Federal Bureau of Investigation (FBI) and other DOJ agencies involved in operations to counter drug use. At the start, the DEA was given 1,470 special agents and a budget of less than \$75 million. Today, the agency has nearly 5,000 agents and a budget of \$2.03 billion. 162

Race, Stigma and Discrimination

During a 1994 interview, President Nixon's domestic policy chief, John Ehrlichman, provided inside information suggesting that the War on Drugs campaign had ulterior motives, which mainly involved helping Nixon keep his job. 163

In the interview, conducted by journalist Dan Baum and published in Harper magazine, Ehrlichman explained that the Nixon campaign had two enemies: "the antiwar left and black people." His comments led many to question Nixon's intentions in advocating for drug reform and whether racism played a role. 164

Ehrlichman was quoted as saying: "We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did." 165

In the mid-1970s, the War on Drugs took a slight hiatus. Between 1973 and 1977, eleven states decriminalized marijuana possession. Jimmy Carter became president in 1977 after running on a political campaign to decriminalize marijuana. During his first year in office, the Senate Judiciary Committee voted to decriminalize up to one ounce of marijuana. ¹⁶⁶

The 1980s and "Say No to Drugs"

In the 1980s, President Ronald Reagan reinforced and expanded many of Nixon's War on Drugs policies. In 1984, his wife Nancy Reagan launched the "Just Say No" campaign, which was an effort to educate children on the dangers of drug use. 167

President Reagan's refocus on drugs led to a significant increase in incarcerations for nonviolent drug crimes.

In 1986, Congress passed the Anti-Drug Abuse Act, which established mandatory minimum prison sentences for certain drug offenses. This law was later heavily criticized as having racist

ramifications because it allocated longer prison sentences for offenses involving the same amount of crack cocaine (used more often by black Americans) as powder cocaine (used more often by white Americans).¹⁶⁸

Critics also pointed to data showing that people of color were targeted and arrested on suspicion of drug use at higher rates than whites, leading to disproportionate incarceration rates among communities of color.¹⁶⁹

1990s to present

The majority of federal drug legislation over the last 20 years focused on synthetic drugs, as different synthetic drugs have waxed and waned in popularity with illicit drug users over the past few decades.

In the 1990s, as the popularity of cocaine decreased, methamphetamine use increased. Methamphetamine was, and is, produced with legally obtainable ingredients including pseudoephedrine, a non-prescription cold medicine. Under the Comprehensive Methamphetamine Control Act of 1996, enhanced criminal penalties were established for the manufacture and distribution of the drug.¹⁷⁰

MDMA, commonly known as ecstasy, rose in popularity in the early 1980s. The DEA then categorized it as a Schedule I drug of the CSA. It resurfaced in the 1990s, and in recent years under the street name "molly".¹⁷¹

Over the past 20 years, 30 states and the District of Columbia have established laws and policies permitting medical and recreation marijuana use; however, cannabis is still illegal under federal law. The federal government categorizes marijuana as a Schedule 1 drug of the CSA, which does not recognize the difference between medical and recreational use of cannabis. These laws are generally applied only against persons who possess, cultivate, or distribute large quantities of cannabis.



Our community has many recovery resources in place, but knowing how to navigate those resources for the appropriate level of care can be confusing and overwhelming.

Ways to get started:

KENTUCKY HELP NOW HOTLINE AND TREATMENT LOCATOR

1.833.859.4357

https://www.FindHelpNowky.org/

The Treatment Locator has the most up-to-date information on services available in the state of Kentucky.

CASEY'S LAW

502.574.6188

https://louisvilleky.gov/government/county-attorney/caseys-law

Casey's Law is a legal proceeding to obtain a court order for involuntary treatment for addiction for adults or children.

RESOURCE	PHONE
Baptist Health Louisville 🔘	502.896.7105
The Brook Hospital 🔘 🔘	502.896.0495
The Brook Hospital - KMI/Substance Abuse Services • • • • • • • • • • • • • • • • • • •	502.426.6380
Center for Behavioral Health 🔘 🔾	502.894.0234
Centerstone Addiction Recover Center OOOOOO	502.583.3951
Certified Counseling Services 🔾 🔾	502.635.2008
The Cleanse Clinic OOO	502.938.0511
Family Health Centers OO	502.772.8118
Greater Louisville Counseling Center O	502.587.9737
The Healing Place (Men) 🔾 🔾 🔾	502.585.4848
The Healing Place (Women)	502.268.6680
Interlink Counseling Services OO	502.964.7147
JourneyPure O	888.601.0982
Kilgore Samaritan Counseling 🔘 🔘	502.327.4622
Landmark Recovery OOO	502.632.0315
MORE Center OOO	502.574.6414
The Morton Center OOO	502.451.1221
New Beginnings - Education Counseling Center, Inc. O	502.493.7794
New Leaf Clinic O	502.435.8321
New Vision, Norton Audubon Hospital 🔘 🔾	502.636.4961
New Vision, Norton Suburban Hospital - Expectant Mothers Program 🔾	502.559.4375
Our Lady of Peace - Adult Outpatient Center 🔘 🔾 🔾	
Our Lady of Peace - Children and Adult Services OOO	502.451.3333
Renew Recovery OO	502.749.6249
Robley Rex Veterans Medical Center 🔘 🔾	502.287.5960
SelfRefind Louisville Clinic 🔘 🔾	866.755.4258
Volunteers of America OOOO	502.635.4530
Recovery House Inpatient Family Prog	ram
Recovery Support Medication Assisted Recovery Pregnant/Pa	arenting/Postpartum
Outpatient O Medical Stabilization	

This is a list of community partners that support recovery in other ways such as navigating recovery resources (the Angel Program), legal support with DUIs (Clear Vision), job/education help (KYRRC) and child care while in recovery (Project Keepsafe). Again, this is not an exhaustive list of community resources!

RESOURCE	PHONE	WEBSITE
The Angel Program (J-town Police Dept)	502.267.0503	https://www.jeffersontownky.com/678/Angel-Program
Choose Well	800.520.4914	http://www.choose-well.org/
Clear Vision Counseling	502.995.3350	https://www.clearvisioncounseling.org/
Home of the Innocents Project Keepsafe	502.596.1221	https://www.homeoftheinnocents.org/services/ residential-treatment/project-keepsafe/
Michael White's Kentucky Recovery Resource Center (KYRRC)	502.356.6101	https://www.michealwhitecenter.com/
Women in Circle	502.213.9058	

Substance use disorder is a chronic condition that requires ongoing, lifetime support for the person and their family members from others that understand the disease. These support groups are a vital part of the recovery process.

RESOURCE	PHONE	WEBSITE			
Alcoholics Anonymous	502.582.1849	http://www.louisvilleaa.org/			
Support groups for adults struggling with alcohol addiction using 12 step program.					
Narcotics Anonymous	502.569.1769	https://www.nalouisville.net/meetings.html			
Support groups for adults struggling with drug addiction using 12 step program.					
Smart Recovery		https://www.smartrecovery.org/local/			
Support groups in person and online using science-based 4-Point Program.					
Refuge Recovery		https://www.refugerecovery.org/			
Herage Hecovery		intebasy / www.cragerecovery.org/			
Support groups that utilizes Buddhis	l st philosophy as foundation of	• • • •			
•	st philosophy as foundation of 502.458.1234	• • • •			
Support groups that utilizes Buddhis	502.458.1234	the recovery process. http://kyal-anon.org/			
Support groups that utilizes Buddhis Al Anon Family Groups	502.458.1234	http://kyal-anon.org/ on struggling with addiction.			
Al Anon Family Groups Support groups for friends/family m Celebrate Recovery	502.458.1234 nembers worried about a pers	the recovery process. http://kyal-anon.org/			

This list of halfway/transitional/recovery/sober housing has a large range in terms of number of residents, locations, expectations/rules, years in operation and cost. Recovery is different for every person and requires the right kind of support at the right time for each situation. This is not a complete list of housing available (or needed) for recovery.

805 Mary Street **Gratitude House** Hope and Favor House 91 Psalms House Arch to Freedom Hope Sisters House Of Recovery Augustine Hall Hosea's House **Beacon House** House of Grace House Of Hope **Brook Street House** Kristy's Love Foundation The Burns M. Brady Center Ladies of Promise **Chestnut House** Corner of Hope Recovery The New Beginning CTS Russell (Community Transitional Services) **New Legacy Reentry Corporation Dismas Charities** Next Step Recovery House **Divine Steps** Our Father's House Driven Purpose Hope Sisters House Of Recovery

Driven Purpose Hope Sisters House
Fountain of Hope Hosea's House
Graceful Living House of Grace
Gateway to Hope Recovery House House Of Hope

Kristy's Love Foundation Ladies of Promise The New Beginning

New Legacy Reentry Corporation Next Step Recovery House Our Father's House Successful Living

Talbot House (Wallace House and Hoard

House)

Transitional House Travelers Living

Wayside Christian Mission

Wellspring (Ardery House & Journey House)

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